AMBULANCE FEE SCHEDULE FINAL RULE AND REIMBURSEMENT STRATEGIES

Terminal Objective:

At the conclusion of this module, the student will be able to discuss the Medicare Ambulance Fee Schedule Final Rule and identify strategies for optimizing reimbursement within its requirements and limitations.

Enabling Objectives:

1. Describe the historical development and programs administered by the Centers for Medicare and Medicaid Services.

2. Identify the requirements of Medicare Part B as they apply to ambulance suppliers, including:

    - Levels of Service
    - Medical Necessity
    - Physician Certification
    - Origins and Destinations
    - Vehicles and Staffing

3. Explain the basic components used to determine the Medicare Ambulance Fee Schedule, including:

    - Relative Value Unit
    - Conversion Factor
    - Emergency Response Adjustment Factor
    - Operational Variations
    - Geographic Adjustment Factor
    - Inflation Factor
    - Mileage

4. Describe the payment policies addressed in the Medicare Ambulance Fee Schedule Final Rule, including:

- Billing Codes
- Billing Method
- Special Circumstances

5. Calculate the base rate for various levels of service for local areas.

6. Discuss various methods and considerations for optimizing reimbursement of claims.

7. Identify various resources to assist organizations in training personnel and facilitate the reimbursement process.

HISTORY OF MEDICARE ADMINISTRATION

The Social Security Act established Medicare in 1965. From 1965 to 1972, Medicare provided health care coverage only to Americans over the age of 65. In 1972, it was expanded to cover those living with disabilities.

The Social Security Act also established Medicaid in 1965. Medicaid is a joint federal-state program that provides health care coverage to low-income families with children under the age of 21, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Medicare and Medicaid currently provide benefits for approximately 70 million Americans.

In 1997, as part of the Balanced Budget Act, Congress created the State Children's Health Insurance Program (SCHIP), which builds on the Medicaid program and allows states to provide health insurance to more children of working families. That same year, administration of these three programs was transferred from Social Security to the Health Care Financing Administration (HCFA) under the Department of Health and Human Services (HHS).

In 2001, HCFA was restructured and renamed as the Centers for Medicare and Medicaid Services (CMS). The new CMS is organized around 3 centers that reflect the agency's major lines of business: traditional fee-for-service Medicare; Medicare+Choice and state-administered programs (Medicaid and SCHIP).

The greatest concern to ambulance providers is the traditional fee-for-service Medicare. The Center for Medicare Management focuses on the traditional fee-for-service Medicare program, including the development of payment policy and management of the Medicare fee-for-service contractors.

Medicare and Ambulance Reimbursement

When Medicare was established, only Basic Life Support (BLS) ambulances were in existence. With the implementation and expansion of services provided at the Advanced Life Support (ALS) level, the cost to Medicare increased dramatically. As a result, the Balanced Budget Act of 1997, charged HCFA with reformulating the ambulance fee structure. This reformulation involved:

- Developing definitions that link payment to type of services furnished (levels of service)
- Identifying appropriate regional and operational variations
- Developing a methodology to phase in the revised payment schedule
- Developing mechanisms to control increase in expenditures and
- Determining adjustments to account for inflation

The Balanced Budget Act specified that the new ambulance fee schedule be established through the negotiated rulemaking process. The Negotiated Rulemaking Committee

consisted of representatives from national organizations, including the American Ambulance Association, American College of Emergency Physicians, National Association of EMS Physicians, American Health Care Association, American Hospital Association, Association of Air Medical Services, International Association of Firefighters, International Association of Fire Chiefs, National Association of Counties, National Association of State Emergency Medical Services Directors, and the National Volunteer Fire Council. A consensus Committee statement was signed February 2000. A history of the Negotiated Rulemaking Committee, including the minutes of meetings, can be accessed at http://www.hcfa.gov/medicare/ambmain.htm.

MEDICARE PART B

Medicare Part B covers ambulance services if the supplier meets the applicable vehicle, staff, and billing and reporting requirements of 42 CFR Subpart B, Section 410.41 and the service meets the medical necessity and origin and destination requirements. As part of the rulemaking process, definitions of various levels of service were developed and described in §414.605.

Level of Service

Medicare defines seven levels of ambulance services.

1. **Basic Life Support (BLS)** - transportation by ground ambulance vehicle and medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). (These laws may vary from State to State.)

2. **Advanced Life Support, level 1 (ALS1)** - transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.

   ALS assessment is defined as an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in the need for ALS level of service.

3. **Advanced Life Support, level 2 (ALS2)** - transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate) OR the provision of at least one of the following ALS procedures:

   - Manual defibrillation/cardioversion

- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line.

Aspirin and oxygen do not qualify a response as an ALS2 level. However, three separate administrations of the same acceptable medication during a single transport does qualify for payment at the ALS2 level.

4. **Specialty Care Transport (SCT)** - interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic (such as nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training). The Rule does not define "additional training" for a paramedic.

5. **Paramedic ALS Intercept (PI)** - EMT-Paramedic services furnished by an entity that does not furnish the ground ambulance transport and meets the following requirements:

    1. Certified to provide ALS services
    2. Qualified to provide services under Medicare
    3. Bills all the recipients who receive ALS intercept services, regardless of whether or not those recipients are Medicare beneficiaries.

    The service must be furnished in an area that is designated as a rural area by any law or regulation of the State or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent Goldsmith Modification). It must also be provided under contract with one or more volunteer ambulance services that meet the following conditions:

    1. Furnish services only at the BLS level
    2. Are prohibited by State law from billing for any services

    As of final rule release, only New York State meets the statutory requirements for paramedic intercept.

6. **Fixed Wing Air Ambulance (FW)** - transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance and such services and supplies as may be medically necessary. Costs are covered when the point from which the beneficiary is transported is inaccessible by land vehicle, or great distances or other obstacles and the medical condition is not appropriate for transport by either BLS or ALS ground ambulance.

7. **Rotary Wing Air Ambulance (RW)** - means transportation by a helicopter that is certified as an ambulance and such services and supplies as may be medically necessary. Costs are covered when the point from which the beneficiary is transported is inaccessible by land vehicle, or great distances or other obstacles and the medical condition is not appropriate for transport by either BLS or ALS ground ambulance.

Medical Necessity

Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated. For non-emergency ambulance transportation, the transport is appropriate if the beneficiary is bed-confined and it is documented that the beneficiary's medical condition is such that other methods of transportation are contraindicated, *or if the medical condition, regardless of bed-confinement, is such that transportation by ambulance is medically required*. The italicized statement is an addition from the new rule.

In determining whether a beneficiary is bed-confined, the following criteria must be met:

1. The beneficiary is unable to get up from the bed without assistance.
2. The beneficiary is unable to ambulate.
3. The beneficiary is unable to sit in a chair or wheelchair.

Physician Certification

Medicare covers non-emergency, scheduled ambulance services if the ambulance supplier obtains a written order from the beneficiary's attending physician certifying the medical necessity requirements before furnishing the service to the beneficiary. If the non-emergency, scheduled ambulance service is repetitive, the physician's order must be dated no earlier than 60 days before the date the service is furnished.

Medicare covers non-emergency, non-repetitive or unscheduled ambulance services if the ambulance supplier, before submitting a claim, obtains:

1. A signed physician certification statement from the attending physician within 48 hours; OR

2. A signed physician certification from either the physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the hospital or facility where the beneficiary is being treated or the beneficiary's attending physician, and who has personal knowledge of the beneficiary's condition at the time the transport is ordered or the service was provided; OR

3. If the supplier is unable to obtain the required statement within 21 calendar days following the date of service. The claim may be submitted after attempts to

obtain the physician certification statement are documented. A signed return receipt from the U.S. Postal Service or similar delivery service will serve as documentation that the ambulance supplier attempted to obtain the required physician certification statement from the beneficiary's attending physician. In all cases, the appropriate documentation must be kept on file and presented to the carrier or intermediary upon request. Numbers 2 and 3 are additions from the new rule.

Origins and Destinations

Medicare covers the following ambulance transportation:

- From any point of origin to the nearest hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF) that is capable of furnishing the required level and type of care. The hospital or CAH must have the type of physician or physician specialist needed to treat the beneficiary's condition available.

- From a hospital, CAH, or SNF to the beneficiary's home.

- From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.

- From the home of a beneficiary with End Stage Renal Disease (ESRD) to the nearest facility that furnishes renal dialysis, including the return trip.

Requirements for Ambulance Suppliers

A vehicle used as an ambulance must meet the following requirements:

- Specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured. The vehicle must comply with all State and local laws governing an emergency transportation vehicle.
- Equipped with emergency warning lights and sirens, as required by State or local laws.
- Equipped with telecommunications equipment as required by State or local law. Equipped with, at a minimum, one two-way voice radio or wireless telephone.
- Equipped with a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment, as required by State or local laws.

A BLS vehicle must be staffed by at least two people, one must be:

- Certified as an emergency medical technician by the State or local authority where the services are furnished.
- Legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS vehicle must be staffed by at least two people, one must be:

- Certified as a paramedic or an emergency medical technician, by the State or local authority where the services are being furnished, to perform one or more ALS services.

An ambulance supplier must comply with the following Billing and Reporting requirements:

- Bill for ambulance services using CMS-designated procedure codes. The claims form must indicate that the physician certification is on file.
- When requested by a carrier, provide documentation of compliance with State/local licensure and certification requirements and provide other additional required information and documentation using designated CMS forms.

AMBULANCE FEE SCHEDULE FINAL RULE

Understanding the fees begins with understanding the components of the fee schedule payment amounts. Payment for each type of ambulance service (ground, air, water) is the sum of a base payment amount plus a mileage rate.

The base payment amount for air ambulance services is the product of:

1. A nationally uniform unadjusted base rate
2. A geographic adjustment factor

The base payment for ground or water ambulance service is the product of:

1. A nationally uniform relative value for the service (RVU)
2. A geographic adjustment factor
3. A nationally uniform conversion factor (CF)

Relative Value Units

The RVU represents the relative resources associated with the various levels of ambulance services. The RVUs were determined based on 1998 Medicare ambulance claims and were established by the Negotiated Rulemaking Committee.

The RVU scale for the ambulance fee schedule is as follows:

Service level	Relative value units (RVUs)
BLS	1.00
BLS-Emergency	1.60
ALS1	1.20
ALS1-Emergency	1.90
ALS2	2.75
SCT	3.25
PI	1.75

Conversion Factor

The conversion factor (CF) was based on the total number of ambulance trips, loaded miles, and the total amount of charges allowed by Medicare for ambulance services in the base year of 1998. The following steps were used to determine the CF.

1. The total volume of 1998 services was coded using the new levels of service.
2. The volume of services for each level of ground ambulance service was multiplied by the respective RVUs.
3. The products of all levels of service were added together to determine the total number of RVUs.
4. The total allowed amount for air ambulance services ($158 million) was subtracted from the total charges allowed for ambulance services, leaving the total amount of charges for ground ambulance services.
5. The total amount of allowed ground mileage charges was subtracted from the total charge amount for ground ambulance services.
6. The remaining charge amount was divided by the total number of RVUs and the cumulative ambulance inflation factor for the period 1998 through 2002 was applied, resulting in a CF for ground ambulance trips of $170.54.

This may be demonstrated graphically as follows:

Determining the Conversion Factor

Step 1 1998 total number of ambulance reimbursements coded to new levels of service.

Step 2 Total volume of Ground Ambulance transports X Respective RVUs

Level of Service		**RVU**		
BLS	X	1.00	=	A
BLS Emergency	X	1.60	=	B
ALS 1	X	1.20	=	C
ALS 1 Emergency	X	1.90	=	D
ALS 2	X	2.75	=	E
SCT	X	3.25	=	F
PI	X	1.75	=	G

Step 3 Add products of all levels of service (A + B + C + D + E + F + G) = Total RVUs.

Step 4 Total allowed amount for all ambulance services
- (minus)
Total allowed amount for air ambulance services
Total amount for ground ambulance services

Step 5 Total amount for ground ambulance services
- (minus)
Total ground mileage charges
Allowed amount for ground ambulance

Step 6 Allowed amount for ground ambulance (divided by) Total RVUs + Inflation Factor = CF

CF = $170.54

Medicare will monitor and evaluate payment data, BLS/ALS volume, and low charge billing to determine the accuracy of the original Conversion Factor. If the actual proportions in these areas are different from the projected amounts, the Conversion Factor will be adjusted and applied prospectively.

The 2002 Fee Schedule For Payment of Ambulance Services can be found in Appendix A of this module.

Emergency Response Adjustment Factor

The Rule recognizes the additional costs incurred with an immediate response and includes an Emergency Response Adjustment Factor. An immediate response is defined

as one in which the ambulance provider "begins as quickly as possible to take the steps necessary to respond to the call." Emergency responses for the BLS and ALS1 levels of service are assigned a higher relative value (RVU). There is no emergency modifier for PI, ALS2, or SCT.

Operational Variations

All ambulance companies, however organized, (public, private, for profit, not-for-profit, volunteer, government-affiliated, institutionally-affiliated, or wholly independent supplier) will be paid according to the ambulance fee schedule, with the exception of Critical Access Hospitals that are the only ambulance provider within a 35 mile drive. These CAHs are exempt from the new ambulance fee schedule.

Geographic Adjustment Factor

The geographic adjustment factor (GAF) reflects the relative cost of living variations among different areas of the country. The geographic practice cost index (GPCI) for ambulance services uses the same geographic areas as the Medicare Physician Fee Schedule and is equal to the practice expense (PE) portion of the geographic practice cost index (GPCI) of the table. The entire Medicare Physician Fee Schedule as well as the PE portion can be found in Appendix B of this module.

The ambulance GPCI is based on the geographic location at which the beneficiary is placed on board the ambulance (point of pick-up) and is applied to 70 percent of the base payment rate for ground ambulance services and 50 percent of the base payment rate for air ambulance services. The GPCI does not apply to the mileage payment rate.

Inflation Factor

The inflation factor is equal to the projected consumer price index (CPI-U) for all urban consumers (U.S. city average) minus 1 percentage point. It is calculated from March-to-March for claims paid under cost payment (providers) and from June-to-June for claims paid under the reasonable charge system (carrier processed claims). The inflation factor was calculated using 1998 as the base year. The inflation factors as percents are:

	March-to-March (Provider Claims)	**June-to-June (Carrier Claims)**
1999/1998	0.9%	1.1%
2000/1999	2.4%	2.0%
2001/2000*	3.7%	3.7%
2002/2001	2.2%	2.2%
Compounded inflation factor (DOS=1/1/02-12/31/02)	9.50%	9.29%

* For date of service (DOS) during the 6-month period 1/1/01 - 6/30/01, the inflation factor was 2.7 percent, and for the 6-month period 7/1/01 - 12/31/01, the statutory inflation factor is 4.7 percent for an average of 3.7 percent for 2001.

The inflation factor for years 2003 through 2006 is estimated to be 2.5 percent; however, annual updates to the fee schedule will make adjustments to account for inflation based on the actual percentage increase in the CPI-U.

Mileage

The Negotiated Rulemaking Committee determined the initial mileage rate using the base year of 1998. The current rates have been adjusted by the ambulance inflation factor for each year since the base year. The mileage rate applies only to **loaded** miles.

Mode	1998	2001
Ground	$5.00	$5.47
Fixed Wing	$6.00	$6.57
Rotary Wing	$16.00	$17.51

Mileage is based on the location the beneficiary is placed on board the ambulance (point of pick-up). The zip code of the point of pick-up must be reported on each claim.

Services in Rural Areas

Medicare defines a rural area as one outside a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area, or an area within an MSA identified as rural, using the Goldsmith modification (rural census tracts located within a large metropolitan county of at least 1,225 square miles).

There is a 50 percent increase applied to both mileage and base rate for air ambulance services. For ground ambulances, there is a 50 percent add-on to the regular mileage rate for each of the first 17 miles identified as rural ($8.21 per mile) and a 25 percent add-on to the regular mileage rate for miles 18 through 50 ($6.84 per mile). The regular mileage allowance applies for every mile over 50 miles ($5.47 per mile). The rural adjustment in this rule is a temporary proxy and Medicare will consider alternative methods for identifying rural ambulance suppliers.

PAYMENT POLICIES

Mandatory Assignment

The new Fee Schedule for Payment of Ambulance Services became effective April 1, 2002. Several of the payment policies addressed in the new rule will be phased in over the five-year transition period. However, there is no transitional period for mandatory assignment. Ambulance suppliers must accept the Medicare allowed charge as payment in full and not bill any amount other than unmet Part B deductible or coinsurance amounts.

Mandatory assignment refers only to services that are covered by the Medicare program and does not preclude billing for additional services such as mileage for transportation to a facility beyond the nearest appropriate facility.

Billing Codes

Claims will be processed using the billing codes created for the ambulance fee schedule. The revised Health Care Common Procedure Coding System (HCPCS) codes became effective January 1, 2001. With a few exceptions, these are the required codes.

The codes previously used to bill supplies and mileage separately may be used during the transition period only. Two new codes have been added, namely Q3019 (ALS emergency transport, no ALS service furnished) and Q3020 (ALS transport, no ALS service furnished). These codes increase payment during the transition for certain transports where no ALS service is furnished.

Appendix C shows how the former codes crosswalk to the final new codes of the fee schedule. The chart also shows the "old" HCPCS codes for items and services that will be bundled into the base rate services at the end of the transition period.

Billing Method

After the transition period, all items and services furnished within the ambulance benefit will be bundled into the base rate payment. This will eliminate itemized billing related to the ambulance service (for example, oxygen, drugs, extra attendants, and EKG testing). Only the base rate code and the mileage code will be used to bill Medicare. During the transition period, suppliers who currently bill separately for supplies or separately for services, supplies, and mileage may continue to do so.

Multiple Patients

If two patients are transported simultaneously, 75% of the base rate applicable to the level of care furnished to each beneficiary is paid. For example, if patient one receives BLS care and patient two receives ALS2 care, Medicare will reimburse 75% of the BLS base rate for patient one and 75% of the ALS2 base rate for patient two.

If three or more patients are transported simultaneously, 60% of the base rate applicable to the level of care furnished to each beneficiary is paid. A single payment for mileage is prorated by the number of patients transported, regardless of the number.

BLS in ALS Vehicle

Where an ALS vehicle is used but no ALS level of service is furnished, claims will be paid at the BLS level. For example, an ALS vehicle furnishes non-emergency BLS service.

The former portion of the blended rate (80% for 2002) will be at the former ALS non-emergency payment level and the new fee portion of the blended rate (20% for 2002) will be at the BLS fee schedule amount.

In the case where an ALS vehicle furnishes only an ALS assessment, the former portion of the blended rate (80% for 2002) will be at the ALS emergency rate and the new fee portion of the blended rate (20% for 2002) will be at the ALS1-Emergency fee schedule amount.

Pronouncement of Death

Medicare payment for beneficiaries who are pronounced dead by an authorized individual during a response is based on when the death is pronounced. If the beneficiary is pronounced prior to the time the ambulance is called, no payment will be made. If the beneficiary is pronounced dead after the ambulance is called but prior to arrival, a ground ambulance will be paid the BLS base rate and air ambulances will be paid the air base rate. No payment for mileage will be made. If the beneficiary is pronounced dead during the transport, the same payment rules apply as if the beneficiary were alive.

Phase-In

The fee schedule will be phased in over 5 years on a calendar year basis as follows:

	Former Payment Percentage	Fee Schedule Percentage
Year 1 (4/2002—12/2002)	80	20
Year 2 (CY 2003)	60	40
Year 3 (CY 2004)	40	60
Year 4 (CY 2005)	20	80
Year 5 (CY 2006)	0	100

Providers must maintain statistics necessary for the Provider Statistics and Reimbursement report to ensure that the ambulance fee schedule portion of the blended transition payment will not be cost-settled at cost settlement time.

The following is an example of payment for an urban ground ambulance under the new 2002 fee schedule:

Use of 2002 Fee Schedule for Urban Ground Ambulance (Independent Supplier)

Reasonable charge IIC	Reasonable charge IIC x 80%	2002 fee schedule	2002 fee schedule x 20%	Total allowed charge
$315.62	**$252.50**	**$343.66**	**$68.73**	**$321.23**

A Medicare beneficiary residing in Baltimore, Maryland, was transported via ground ambulance from home to the nearest appropriate hospital 2 miles away. An emergency response was required, and an ALS assessment was performed. Therefore, the level of service is ALS1-Emergency.

Assuming that the beneficiary was placed on board the ambulance in Baltimore, it will be an urban trip. Therefore, no rural payment rate will apply. In Baltimore, the GPCI = 1.038. The fee schedule amount will be calculated as follows--

Payment Rate = [(RVU*(0.30+(0.70*GPCI)))*CF]+[MGR*#MILES]
Payment Rate = [(1.90*(0.30+(0.70*1.038)))*170.54]+[5.47*2.00]
Payment Rate = [(1.90*(0.30+0.727))*170.54]+[10.94]
Payment Rate = [(1.90*1.027)*170.54]+[10.94]
Payment Rate = [1.951*170.54]+[10.94]
Payment Rate = [332.724]+[10.94]
Payment Rate = 343.664
Payment Rate = $343.66 (subject to Part B deductible and coinsurance requirements)

Because 2002 will be the first year of a 5-year transition period, the ambulance fee schedule payment rate will be multiplied by 20 percent and added to 80 percent of the payment calculated by the current payment system. The applicable codes are A0427 and A0425. Assuming application of the inflation indexed charge (IIC) in 2002, the reasonable charge allowance for this service in Maryland is $315.62 ($303.00 for the base trip plus $6.31 X 2 miles).

Assuming that the Part B deductible has been met, the program will pay 80 percent, and the beneficiary's liability will be 20 percent, representing the Part B coinsurance amount, and the total allowed charge for this service during CY 2002 will be:

Medicare Payment (80%)	Beneficiary Liability(20%)
$256.98	$64.25

The following is an example of payment for a rural ground ambulance under the new 2002 fee schedule:

Use of 2002 Fee Schedule for Rural Ground Ambulance (Independent Supplier)

Reasonable charge IIC	**Reasonable charge IIC x 80%**	**2002 fee schedule**	**2002 fee schedule x 20%**	**Total allowed charge**
$292.44	**$233.95**	**$425.62**	**$85.12**	**$319.07**

A Medicare beneficiary residing in Cottle County, Texas was transported via ground ambulance from home to the nearest appropriate facility located in Quanah, Texas. Cottle County, where the beneficiary was placed on board the ambulance, is a non-MSA, therefore, is considered rural for purposes of this fee schedule. A rural mileage rate will apply. The total distance from the beneficiary's home to the facility is 36 miles. A BLS non-emergency assessment was performed. The level of service will be BLS non-emergency.

For this part of Texas, the GPCI = 0.880. The proposed ambulance fee schedule amount will be calculated as follows--

> 36 mile trip = 17 miles at the 50% rural mileage increased rate plus 19 miles at the 25% rural mileage increased rate.

Payment Rate = [(RVU*(0.30+(0.70*GPCI)))*CF]+[(((1+RG1)*MGR)*#MILES≤17)+(((1+RG2)*MGR)*#MILES18-50)+(MGR*#MILES>50)]
Payment Rate = [(1.00*(0.30+(0.70*0.880)))*170.54]+[(((1.00+0.50)*5.47)*17.00)+(((1.00+0.25)*5.47)*19.00)+(5.47*0.00)]
Payment Rate = [(1.00*(0.30+0.616))*170.54]+[((1.50*5.47)*17.00)+((1.25*5.47)*19.00)+(0.00)]
Payment Rate = [(1.00*0.916)*170.54]+[(8.21*17.00)+(6.84*19.00)+(0.00)]
Payment Rate = [0.916*170.54]+[139.49+129.91+0.00]
Payment Rate = [156.215]+[269.40]
Payment Rate = 425.615
Payment Rate = $425.62 (subject to Part B deductible and coinsurance requirements)

The total allowed charge for this service during 2002 is based on the following codes:
Old HCPCS Code(s) = A0300 and A0380
New HCPCS Code(s) = A0428 and A0425

Assuming application of the inflation indexed charge (IIC) in 2002, the reasonable charge rate for this service in Texas will be $292.44 ($152.76 for HCPCS A0300, $3.88 X 36 miles for A0380).

Assuming that the Part B deductible was met, the program will pay 80 percent, and the beneficiary's liability will be 20 percent, representing the Part B coinsurance amount and the total allowed charge for this service during 2002 will be:

Medicare Payment (80%)	Beneficiary Liability (20%)
$255.26	$63.81

Calculating Your Base Rate

You can calculate your base rate for each level of service you provide. As an example the following is a calculation of the base rate for an ALS2 response in Galveston, Texas:

ALS2 level unadjusted base rate = $468.99

Ambulance GPCI for Galveston, TX = 0.969
70% of ALS2 unadjusted rate = $328.29
$328.29 (70% of ALS2 unadjusted rate) X 0.969 (GPCI) = $318.11
$318.11 + $140.70 (remaining 30% of ALS2 unadjusted rate) = $458.81

Locate the Practice Expense for your area from the Practical Expense table in Appendix B. This is your GPCI. REMEMBER: The GPCI is determined by the place in which the beneficiary is loaded onto the ambulance (point of pick-up), NOT by the location of your ambulance service's station(s).

Once you determine your GPCI, take 70% of the appropriate unadjusted base rate from one the 7 levels of service from the table below and multiply that by the GPCI for your area. Add the remaining 30% of the unadjusted base rate to determine the base rate for your service.

Service level	Unadjusted base rate	Your base rate
BLS	$170.54	
BLS-Emergency	$272.86	
ALS1	$204.65	
ALS1-Emergency	$324.03	
ALS2	$468.99	
SCT	$554.26	
PI	$298.45	

REIMBURSEMENT STRATEGIES

It is critical during the transition that ambulance providers develop strategies to optimize their reimbursement and reduce claim denial. Electronic billing, knowledge of current rules and regulations, and experienced staffing minimize the error rate on claims and shorten the turnaround time for payments

Causes of Claim Denial

One of the more common reasons for claim denial is using inappropriate or inaccurate codes. Coding will be greatly simplified following the transition period since only the base rate code and mileage code will be used. Other causes of claim denial include:

- Losing charge information or billing insurance carriers incorrectly or irregularly.
- Not having and/or following written policies and procedures that support the billing, coding and collections processes.
- Not using appropriate/current forms and documents.

Educating Personnel

Training personnel is critical to optimizing reimbursement for all patient transports, not only Medicare. Personnel should have a basic understanding of the billing process and related terminology. All personnel need to understand the requirements of the new Medicare rule and the required information for claim approval. They must know how to review records to assure billing and demographic information is present and accurate. Written policies and procedures related to billing must be current and personnel must be familiar with them. The policies and procedures and current reference material, such as the HCPCS codes and all relevant zip codes, should be available to personnel.

Training and Information Resources

CMS provides a Carrier Training Manual. Local carrier/intermediaries also may offer additional training opportunities and can answer questions related to the new fee structure. CMS has ambulance billing specialists available to answer questions concerning billing to fiscal intermediaries and provide information on submitting claims. For information concerning billing to fiscal intermediaries, you should contact Nicole Atkins at 410-786-8278. For information on submitting claims to the carrier, you should contact Dolores Crujeiras at 410-786-7169.

Resource links:

- CMS Training Manual: http://www.hcfa.gov/medlearn/afsmanual.htm
- Local carrier/intermediaries list: http://www.hcfa.gov/medlearn/weblnks.htm
- NIH Ambulance-List Serve (which contains the Ambulance Fee Schedule Policy and Instructions): http://list.nih.gov/archives/ambulance-l.html

CMS billing inquiries may also be emailed to jbroseken@dmv.hhs.gov

Other Strategies

<u>Billing Software</u>

Billing software allows for electronic and timely submission of claims. There is a variety of billing software packages available. In addition to cost, organizations should research the capability of the software and the support provided by the vendor for training personnel. Medicare offers a variety of coding, practice, and fee analysis software. These can be viewed and ordered online at: http://www.hcfa-1500-forms.com/coding-software/index.html.

Billing Service

A billing service may be of benefit to many ambulance providers. There are many billing services that specialize in ambulance transports. Billing services use personnel who are experienced in the requirements of insurance carriers and often improve collection rates for ambulance services considerably.

The majority of billing services submit claims electronically. In addition to the initial submission, these services will conduct secondary billing and provide detailed financial reports of revenue collected and aged account receivables. Many services will customize reports for the contracting provider, suggest strategies to optimize revenue based on changing insurance guidelines, and provide training to personnel. Ambulance providers should develop a list of what services they require and research various billing services to ensure they obtain the services they need.

Review Your Charge Structure

Providers should review their charge structures to ensure they are billing at appropriate levels to receive the maximum entitled revenue. **If the amount you actually bill Medicare for the service, is less than the fee schedule payment, Medicare will pay the lesser amount.**

SUMMARY

Although there are still many unknowns to face during the phase-in period, the transition will be easier if ambulance providers invest the time to assess the organization's strengths and weaknesses related to billing practices and educate their members in billing requirements. This investment can have a significant impact on optimizing reimbursement. Appendix D contains a checklist to assist in assessing an organization's billing practices.

BIBLIOGRAPHY

Centers for Medicare and Medicaid. (2002). *Ambulance Fee Schedule Final Rule* [On-line], Available: http://www.hcfa.gov/regs/CMS1002FC.doc

Centers for Medicare and Medicaid. (2002). *Medicare and Medicaid Provisions of Balanced Budget Act of 1997* [On-line], Available: http://www.hcfa.gov/regs/bbaupdat.htm

Code of Federal Regulations. (2001). *§42CFR410.41*: *Requirements for ambulance suppliers.* U.S. Government Printing Office: Washington, D.C.

Code of Federal Regulations. (2001). *§42CFR410.40*: *Coverage of ambulance services.* U.S. Government Printing Office: Washington, D.C.

Federal Register. (2001). *Vol 65, No. 212: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for CalendarYear 2001.* U.S. Government Printing Office: Washington, D.C.

Health and Human Services. (2002). *HHS Fact Sheet*. [On-line], Available: http://www.hhs.gov/news

SUGGESTED READING

Centers for Medicare and Medicaid (2002). *CMS Training Manual.* [On-line], Available: http://www.hcfa.gov/medlearn/afsmanual.htm

Centers for Medicare and Medicaid (2001). *Negotiated Rulemaking Committee Minutes*. [On-line], Available: http://www.hcfa.gov/medicare/ambmain.htm

Appendix A:
2002 Fee Schedule

TABLE 1
2002 FEE SCHEDULE FOR PAYMENT OF AMBULANCE SERVICES

Service level	RVUs	CF	Unadjusted base rate (UBR)+	Amount adjusted by GPCI (70% of UBR)	Amount not adjusted (30% of UBR)	Loaded mileage	Rural ground mileage (miles 1-17)	Rural ground mileage (miles 18-50)*
BLS	1.00	170.54	$170.54	$121.65	$52.14	$5.47	$8.21	$6.84
BLS-Emergency	1.60	170.54	272.86	191.00	81.86	5.47	8.21	6.84
ALS1	1.20	170.54	204.65	143.26	61.40	5.47	8.21	6.84
ALS1-Emergency	1.90	170.54	324.03	226.82	97.21	5.47	8.21	6.84
ALS2	2.75	170.54	468.99	328.29	140.70	5.47	8.21	6.84
SCT	3.25	170.54	554.26	387.98	166.28	5.47	8.21	6.84
PI	1.75	170.54	298.45	208.91	89.54	(1) No Mileage Rate		

Service level	Unadjusted base rate (UBR)	Amount adjusted by GPCI (50% of UBR)	Amount not adjusted (50% of UBR)	Rural air base rate**	Loaded mileage	Rural air mileage***
FW	$2,314.51	$1,157.26	$1,157.26	$3,471.77	$6.57	$9.86
RW	2,690.96	1,345.48	1,345.48	4,036.44	17.51	26.27

* A 50 percent add-on to the mileage rate (that is, a rate of $8.21 per mile) for each of the first 17 miles identified as rural. A 25 percent add-on to the mileage rate (that is, a rate of $6.84 per mile) for miles 18 through 50 identified as rural. The regular mileage allowance applies for every mile over 50 miles.

** A 50 percent add-on to the air base rate is applied to air trips identified as rural.

*** A 50 percent add-on to the air mileage rate is applied to every mile identified as rural.

The payment rate for rural air ambulance (rural air mileage rate and rural air base rate) is 50 percent more than the corresponding payment rate for urban services (that is, the sum of the base rate adjusted by the geographic adjustment factor and the mileage).

+ This column illustrates the payment rates without adjustment by the GPCI. The conversion factor (CF) has been inflated for CY 2002.

Legend for Table 1

ALS1 - Advanced Life Support, Level 1
ALS2 - Advanced Life Support, Level 2
BLS - Basic Life Support
CF - Conversion Factor
FW - Fixed Wing
GPCI - Practice Expense Portion of the Geographic Practice Cost Index from the Physician Fee Schedule
PI - Paramedic ALS Intercept
RVUs - Relative Value Units
RW - Rotary Wing
SCT - Specialty Care Transport

UBR - Unadjusted Base Rate

FORMULAS--The amounts in the above chart are used in the following formulas to determine the fee schedule payments--

Ground:
Ground-Urban:
Payment Rate = [(RVU*(0.30+(0.70*GPCI)))*CF]+[MGR*#MILES]
Ground-Rural:
Payment Rate = [(RVU*(0.30+(0.70*GPCI)))*CF]+[(((1+RG1)*MGR)*#MILES≤17)+ (((1+RG2)*MGR)*#MILES18-50)+(MGR*#MILES>50)] (Sign before number 17 was erroneously published in the proposed rule.)

Air:
Air-Urban:
Payment Rate = [((UBR*0.50)+((UBR*0.50)*GPCI))]+[MAR*#MILES]

Air-Rural:
Payment Rate = [(1.00+RA)*((UBR*0.50)*GPCI))]+[(1.00+RA)*(MAR*#MILES)]

Legend for Formulas

Symbol	Meaning
#	less than or equal to
	greater than
*	multiply
CF	conversion factor (ground = $159.56; air = 1.0)
GPCI	practice expense portion of the geographic practice cost index from the physician fee schedule
MAR	mileage air rate (fixed wing rate = 6.49, helicopter rate = 17.30)
MGR	mileage ground rate (5.40)
#MILES	number of miles the beneficiary was transported
#MILES≤17	number of miles the beneficiary was transported less than or equal to 17
#MILES18-50	number of miles beneficiary was transported between 18 and 50
#MILES>50	number of miles the beneficiary was transported greater than 50
RA	rural air adjustment factor (0.50 on entire claim)
Rate	maximum allowed rate from ambulance fee schedule
RG1	rural ground adjustment factor amount: first 17 miles (0.50 on first 17 miles)
RG2	rural ground adjustment factor amount: miles 18 through 50 (0.25 on miles 18 through 50)
RVUs	relative value units (from chart)
UBR	the payment rates without adjustment by the GPCI (unadjusted base rate)

NOTES: The GPCI is determined by the address (zip code) of the point of pickup.

Appendix B: Physician GPCI Fee Schedule and Practice Expense

DATE: Wednesday, November 1, 2000

Addendum D.--2002 Geographic Practice Cost Indices by Medicare Carrier and Locality

Carrier No.	Locality No.	Locality name	Work	Practice Expense	Malpractice
00510	00	ALABAMA	0.978	0.870	0.807
00831	01	ALASKA	1.064	1.172	1.223
00832	00	ARIZONA	0.994	0.978	1.111
00520	13	ARKANSAS	0.953	0.847	0.340
02050	26	ANAHEIM/SANTA ANA, CA	1.037	1.184	0.955
02050	18	LOS ANGELES, CA	1.056	1.139	0.955
31140	03	MARIN/NAPA/SOLANO, CA	1.015	1.248	0.687
31140	07	OAKLAND/BERKELEY, CA	1.041	1.235	0.687
31140	05	SAN FRANCISCO, CA	1.068	1.458	0.687
31140	06	SAN MATEO, CA	1.048	1.432	0.687
31140	09	SANTA CLARA, CA	1.063	1.380	0.639
02050	17	VENTURA, CA	1.028	1.125	0.783
02050	99	REST OF CALIFORNIA *	1.007	1.034	0.748
31140	99	REST OF CALIFORNIA *	1.007	1.034	0.748
00824	01	COLORADO	0.985	0.992	0.840
10230	00	CONNECTICUT	1.050	1.156	0.966
00902	01	DELAWARE	1.019	1.035	0.712
00903	01	DC + MD/VA SUBURBS	1.050	1.166	0.909
00590	03	FORT LAUDERDALE, FL	0.996	1.018	1.877
00590	04	MIAMI, FL	1.015	1.052	2.528
00590	99	REST OF FLORIDA	0.975	0.946	1.265
00511	01	ATLANTA, GA	1.006	1.059	0.935
00511	99	REST OF GEORGIA	0.970	0.892	0.935
00833	01	HAWAII/GUAM	0.997	1.124	0.834
05130	00	IDAHO	0.960	0.881	0.497
00952	16	CHICAGO, IL	1.028	1.092	1.797
00952	12	EAST ST. LOUIS, IL	0.988	0.924	1.691
00952	15	SUBURBAN CHICAGO, IL	1.006	1.071	1.645
00952	99	REST OF ILLINOIS	0.964	0.889	1.157
00826	00	IOWA	0.959	0.876	0.596

00650	00	KANSAS *	0.963	0.895	0.756
00740	04	KANSAS *	0.963	0.895	0.756
00660	00	KENTUCKY	0.970	0.866	0.877
00528	01	NEW ORLEANS, LA	0.998	0.945	1.283
00528	99	REST OF LOUISIANA	0.968	0.870	1.073
31142	03	SOUTHERN MAINE	0.979	0.999	0.666
31142	99	REST OF MAINE	0.961	0.910	0.666
00901	01	BALTIMORE/SURR. CNTYS, MD	1.021	1.038	0.916
00901	99	REST OF MARYLAND	0.984	0.972	0.774
31143	01	METROPOLITAN BOSTON	1.041	1.239	0.784
31143	99	REST OF MASSACHUSETTS	1.010	1.129	0.784
00953	01	DETROIT, MI	1.043	1.038	2.738
00953	99	REST OF MICHIGAN	0.997	0.938	1.571
10240	00	MINNESOTA	0.990	0.974	0.452
10250	00	MISSISSIPPI	0.957	0.837	0.779
00740	02	METROPOLITAN KANSAS CITY, MO	0.988	0.967	0.846
00523	01	METROPOLITAN ST. LOUIS, MO	0.994	0.938	0.846
00740	99	REST OF MISSOURI *	0.946	0.825	0.793
00523	99	REST OF MISSOURI *	0.946	0.825	0.793
00751	01	MONTANA	0.950	0.876	0.727
00655	00	NEBRASKA	0.948	0.877	0.430
00834	00	NEVADA	1.005	1.039	1.209
31144	40	NEW HAMPSHIRE	0.986	1.030	0.825
00805	01	NORTHERN NJ	1.058	1.193	0.860
00805	99	REST OF NEW JERSEY	1.029	1.110	0.860
00521	05	NEW MEXICO	0.973	0.900	0.902
00803	01	MANHATTAN, NY	1.094	1.351	1.668
00803	02	NYC SUBURBS/LONG I., NY	1.068	1.251	1.952
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.011	1.075	1.275
14330	04	QUEENS, NY	1.058	1.228	1.871
00801	99	REST OF NEW YORK	0.998	0.944	0.764
05535	00	NORTH CAROLINA	0.970	0.931	0.595
00820	01	NORTH DAKOTA	0.950	0.880	0.657
16360	00	OHIO	0.988	0.944	0.957
00522	00	OKLAHOMA	0.968	0.876	0.444

00835	01	PORTLAND, OR	0.996	1.049	0.436
00835	99	REST OF OREGON	0.961	0.933	0.436
00865	01	METROPOLITAN PHILADELPHIA, PA	1.023	1.092	1.413
00865	99	REST OF PENNSYLVANIA	0.989	0.929	0.774
00973	20	PUERTO RICO	0.881	0.712	0.275
00870	01	RHODE ISLAND	1.017	1.065	0.883
00880	01	SOUTH CAROLINA	0.974	0.904	0.279
00820	02	SOUTH DAKOTA	0.935	0.878	0.406
05440	35	TENNESSEE	0.975	0.900	0.592
00900	31	AUSTIN, TX	0.986	0.996	0.859
00900	20	BEAUMONT, TX	0.992	0.890	1.338
00900	09	BRAZORIA, TX	0.992	0.978	1.338
00900	11	DALLAS, TX	1.010	1.065	0.931
00900	28	FORT WORTH, TX	0.987	0.981	0.931
00900	15	GALVESTON, TX	0.988	0.969	1.338
00900	18	HOUSTON, TX	1.020	1.007	1.336
00900	99	REST OF TEXAS	0.966	0.880	0.956
00910	09	UTAH	0.976	0.941	0.644
31145	50	VERMONT	0.973	0.986	0.539
00973	50	VIRGIN ISLANDS	0.965	1.023	1.002
10490	00	VIRGINIA	0.984	0.938	0.500
00836	02	SEATTLE (KING CNTY), WA	1.005	1.100	0.788
00836	99	REST OF WASHINGTON	0.981	0.972	0.788
16510	16	WEST VIRGINIA	0.963	0.850	1.378
00951	00	WISCONSIN	0.981	0.929	0.939
00825	21	WYOMING	0.967	0.895	1.005

*Payment locality is serviced by two carriers.

Note: Work GPCI is the 1/4 work GPCI required by Section 1848(e)(1)(A)(iii) of the Social Security Act. GPCIs rescaled by the following factors for budget netrality: Work = 0.99699; Practice Expense = 0.99235; Malpractice Expense 1.00215.

DATE: Wednesday, November 1, 2000

Addendum D.--2002 Geographic Practice Cost Indices by Medicare Carrier and Locality

Carrier No.	Locality No.	Locality name	Practice Expense
00510	00	ALABAMA	0.870
00831	01	ALASKA	1.172
00832	00	ARIZONA	0.978
00520	13	ARKANSAS	0.847
02050	26	ANAHEIM/SANTA ANA, CA	1.184
02050	18	LOS ANGELES, CA	1.139
31140	03	MARIN/NAPA/SOLANO, CA	1.248
31140	07	OAKLAND/BERKELEY, CA	1.235
31140	05	SAN FRANCISCO, CA	1.458
31140	06	SAN MATEO, CA	1.432
31140	09	SANTA CLARA, CA	1.380
02050	17	VENTURA, CA	1.125
02050	99	REST OF CALIFORNIA *	1.034
31140	99	REST OF CALIFORNIA *	1.034
00824	01	COLORADO	0.992
10230	00	CONNECTICUT	1.156
00902	01	DELAWARE	1.035
00903	01	DC + MD/VA SUBURBS	1.166
00590	03	FORT LAUDERDALE, FL	1.018
00590	04	MIAMI, FL	1.052
00590	99	REST OF FLORIDA	0.946
00511	01	ATLANTA, GA	1.059
00511	99	REST OF GEORGIA	0.892
00833	01	HAWAII/GUAM	1.124
05130	00	IDAHO	0.881
00952	16	CHICAGO, IL	1.092
00952	12	EAST ST. LOUIS, IL	0.924
00952	15	SUBURBAN CHICAGO, IL	1.071
00952	99	REST OF ILLINOIS	0.889
00826	00	IOWA	0.876

00650	00	KANSAS *	0.895
00740	04	KANSAS *	0.895
00660	00	KENTUCKY	0.866
00528	01	NEW ORLEANS, LA	0.945
00528	99	REST OF LOUISIANA	0.870
31142	03	SOUTHERN MAINE	0.999
31142	99	REST OF MAINE	0.910
00901	01	BALTIMORE/SURR. CNTYS, MD	1.038
00901	99	REST OF MARYLAND	0.972
31143	01	METROPOLITAN BOSTON	1.239
31143	99	REST OF MASSACHUSETTS	1.129
00953	01	DETROIT, MI	1.038
00953	99	REST OF MICHIGAN	0.938
10240	00	MINNESOTA	0.974
10250	00	MISSISSIPPI	0.837
00740	02	METROPOLITAN KANSAS CITY, MO	0.967
00523	01	METROPOLITAN ST. LOUIS, MO	0.938
00740	99	REST OF MISSOURI *	0.825
00523	99	REST OF MISSOURI *	0.825
00751	01	MONTANA	0.876
00655	00	NEBRASKA	0.877
00834	00	NEVADA	1.039
31144	40	NEW HAMPSHIRE	1.030
00805	01	NORTHERN NJ	1.193
00805	99	REST OF NEW JERSEY	1.110
00521	05	NEW MEXICO	0.900
00803	01	MANHATTAN, NY	1.351
00803	02	NYC SUBURBS/LONG I., NY	1.251
00803	03	POUGHKPSIE/N NYC SUBURBS, NY	1.075
14330	04	QUEENS, NY	1.228
00801	99	REST OF NEW YORK	0.944
05535	00	NORTH CAROLINA	0.931
00820	01	NORTH DAKOTA	0.880
16360	00	OHIO	0.944
00522	00	OKLAHOMA	0.876

00835	01	PORTLAND, OR	1.049
00835	99	REST OF OREGON	0.933
00865	01	METROPOLITAN PHILADELPHIA, PA	1.092
00865	99	REST OF PENNSYLVANIA	0.929
00973	20	PUERTO RICO	0.712
00870	01	RHODE ISLAND	1.065
00880	01	SOUTH CAROLINA	0.904
00820	02	SOUTH DAKOTA	0.878
05440	35	TENNESSEE	0.900
00900	31	AUSTIN, TX	0.996
00900	20	BEAUMONT, TX	0.890
00900	09	BRAZORIA, TX	0.978
00900	11	DALLAS, TX	1.065
00900	28	FORT WORTH, TX	0.981
00900	15	GALVESTON, TX	0.969
00900	18	HOUSTON, TX	1.007
00900	99	REST OF TEXAS	0.880
00910	09	UTAH	0.941
31145	50	VERMONT	0.986
00973	50	VIRGIN ISLANDS	1.023
10490	00	VIRGINIA	0.938
00836	02	SEATTLE (KING CNTY), WA	1.100
00836	99	REST OF WASHINGTON	0.972
16510	16	WEST VIRGINIA	0.850
00951	00	WISCONSIN	0.929
00825	21	WYOMING	0.895

Appendix C: HCPCS Codes

Codes Not Valid Under the New Fee Schedule (Codes Terminate Effective 01/01/06):

A0382, A0384, A0392, A0396, A0398, A0420, A0422, A0424, A0999

HCPCS Code Changes:

Current HCPCS Code	New HCPCS Code	Descriptions of Final New Codes
A0380, A0390	A0425	Ground mileage (per statute mile).
A0306, A0326, A0346, A0366	A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1).
A0310, A0330, A0350, A0370	A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency).
A0300, A0304*, A0320, A0324*, A0340, A0344*, A0360, A0364*	A0428	Ambulance service, basic life support, non-emergency transport (BLS).
A0050, A0302, A0308**, A0322, A0328**, A0342, A0348**, A0362, A0368**	A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency).
A0030	A0430	Ambulance service, conventional air services, transport, one way (fixed wing (FW)).
A0040	A0431	Ambulance service, conventional air services, transport, one way (rotary wing (RW)).
Q0186	A0432	Paramedic ALS intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by State law from billing third party payers.
	A0433	Advanced life support, Level 2 (ALS2). The administration of at least three different medications and/or the provision of one or more of the following ALS procedures: Manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line.
	A0435	Air mileage; fixed wing (per statute mile).

	A0436	Air mileage; rotary wing (per statute mile).
	A0434	Specialty Care Transport (SCT). In a critically injured or ill beneficiary, a level of inter-facility service provided beyond the scope of the Paramedic. This service is necessary when a beneficiary's condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training).
	Q3019	Ambulance service, Advanced Life Support (ALS) vehicle used, emergency transport, no ALS level service furnished
	Q3020	Ambulance service, Advanced Life Support (ALS) vehicle used, non-emergency transport, no ALS level service furnished

* A new code will be established to indicate during the transition period that where an ALS vehicle was used in a non-emergency situation to furnish only BLS services, the service will be ALS-nonemergency for the old portion of the blended payment and BLS for the Fee Schedule portion of the blended payment.

** A new code will be established to indicate during the transition period that where an ALS vehicle was used in an emergency response and furnished only BLS services, the service will be ALS-Emergency for the old portion of the blended payment and BLS-Emergency for the Fee Schedule portion of the blended payment.

Appendix D:

Organization Checklist

ORGANIZATION ASSESSMENT CHECKLIST

[ ] Identify Levels of Service provided

[ ] Calculate base rate for each level for each year of phase-in using the Ambulance GPCI (Physician Practical Expense factor).

[ ] Review current billing rate to determine estimated effect (increase or decrease in revenue)

- If current rates are lower than allowed fee, consider restructuring fee schedule

[ ] Review collection rates/bad debts/claim denials

- Contact intermediary to determine cause of claim denial, isolate primary causes
- Review existing billing cycles; secondary billing procedures

[ ] Review existing billing policies and procedures

- Assess advantages versus cost of electronic billing if not currently using this method.
- Are forms in use current?
- Are claims submitted regularly?
- What is the average claims processing time?

[ ] Revise and update billing policies and procedures to address fee schedule requirements

[ ] Assess knowledge and experience of current billing personnel

- Are personnel knowledgeable regarding whom to contact for questions?
- Is correct contact information for questions to insurance carriers available?

[ ] Consider advantages of billing service

- If currently using a billing service, contact and discuss their actions regarding the fee schedule

    - What changes are required in the current submission practices of the organization?
    - Will they provide training to organization personnel?

[ ] Assess current knowledge level of personnel regarding billing requirements

[ ] Arrange for training officer to conduct training of personnel

- CMS Training Manual
- Intermediary-provided training

[ ] Assure resources are available to all personnel

- HCPCS Codes
- Zip codes, etc.